New Hampshire

CNS Stimulant/ADHD Medication

NH Medicaid Prior Authorization/Non-Preferred Drug Approval Form

Fax: 1-888-603-7696 Phone: 1-866-675-7755

First Health Services

Date of Medication Request: ___ ___ /___ ___ /___ ___ ___ ___

SECTION I: Patient Information and Medication Requested

Name: (Last, First) _____ NH Medicaid #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Date of Birth: ___ ___ /___ ___ /___ ___ ___ ___ Gender: ☐ Male ☐ Female

Drug Name: _____ Strength: _____

Dosing Directions:_____ Length of Therapy: _____

SECTION II: Clinical History

1. Patient's diagnosis for use of this medication:
   - ☐ Narcolepsy (methylphenidate, modafinil, pemoline, and amphetamines)
   - ☐ Attention Deficit Disorder (methylphenidate, dexmethylphenidate, amphetamines or pemoline)
   - ☐ Depression w/marked fatigue associated with Cancer, HIV, Traumatic Brain injury, or other debilitating condition. Explain:_____
   - ☐ Fatigue in MS
2. Is there any additional information that would help in the decision making process? _____

If you are requesting a non-preferred product, proceed to Section III. If not, then proceed to Section IV.

SECTION III: Non-Preferred Drug Approval Criteria

Chapter 188 of the Laws of 2004 requires that Medicaid only cover non-preferred drugs upon a finding of medical necessity by the prescribing physician. Chapter 188 requires that you base your determination of medical necessity on the following criteria.

- ☐ Allergic reaction ☐ Drug-to-drug interaction. Please describe reaction: _____
- ☐ Previous episode of an unacceptable side effect or therapeutic failure. Please provide clinical information: _____
- ☐ Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to a preferred drug. Please provide clinical information: _____
- ☐ Age specific indications. Please provide patient age and explain: _____
- ☐ Unique clinical indication supported by FDA approval or peer reviewed literature. Please explain and provide a reference:_____
- ☐ Unacceptable clinical risk associated with therapeutic change. Please explain: _____

SECTION IV: Prescriber Information

Name: _____ DEA Number: ____ ____ ____ ____ ____ ____ ____ ____ ____

Phone #: (____ ____ ____) ____ ____ ____ - ____ ____ ____ ____ Fax #: (____ ____ ____) ____ ____ ____ - ____ ____ ____ ____

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

_____
Signature of Prescribing Provider

Revised 5/1/05